Personal Theory: Capstone Project

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Abstract

Developing a personal theory provides a basis for assessment, treatment planning, and outcome assessment during the therapeutic process. Using a TF-CBT approach, I discuss the importance of the initial evaluation to inform treatment protocols and important considerations for assessment. I discuss how this information is used in developing a case conceptualization. This paper outlines my specific approach to counseling and how it applies to an individual with major depressive disorder, recurrent, moderate, and post-traumatic stress disorder, chronic. Finally, a case conceptualization is presented with a treatment plan for services.

Keywords: TF-CBT, case conceptualization, posttraumatic stress disorder, major depressive disorder, assessment, treatment planning, outcomes

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Developing a theoretically grounded model for counseling provides the foundation for approaching the assessment and treatment of mental health disorders. Without a theoretical approach to anchor sessions, appointments can become off-topic and lead to poorer outcomes than the initial presentation to services. This paper outlines my specific approach to assessment using a cognitive behavioral approach to trauma therapy.

Comprehensive Theoretically Grounded Model of Clinical Counseling

Trauma-focused cognitive behavioral therapy (TF-CBT) provides the theoretical foundation for my counseling approach, as trauma is becoming more and more common for individuals receiving mental health services (Field et al., 2019; Wymer et al., 2020). Trauma impacts physical, mental, occupational, and social functioning (Wymer et al., 2020), and TF-CBT targets automatic thoughts, cognitive resiliency, emotional regulation, and increased safety to improve these areas of functioning (Antony & Barlow, 2020; Sperry & Sperry, 2020; Wymer et al., 2020). The TF-CBT treatment method focuses on the individual receiving services as the expert in their life and encourages active participation in sessions (Ehlers et al., 2021; Seligman & Reichenberg, 2014). The *Diagnostic and Statistical Manual, 5th edition, text revision* (DSM-5-TR) provides multiple resources on assessing symptomology to inform treatment protocols.

Comprehensive Method of Assessment

Before the first session, I request the individual complete an intake assessment that provides thorough background information on medical history, family challenges, trauma history, addictive behaviors, spiritual resources, and current symptomology and concerns. I use this to guide my intake session to gather additional information on areas I feel need clarification to determine symptom presentation, precipitants, and perpetuants. CBT assessment focuses on

how maladaptive thoughts influence emotional and behavioral challenges, which then provide feedback on thoughts and belief systems (Sperry & Sperry, 2020). General wellness assessments determine deficits in various areas of functioning and can be used throughout therapy to assess treatment progress. I use the analogy of a puzzle with my clients to describe how I approach therapy; they give me random puzzle pieces, and I work with them to put pieces together to see a fuller picture of their life story.

Biological Assessment

Mental health is a component of physical wellness, and unstable physical conditions can exacerbate mental health (Antony & Barlow, 2020). If an individual has not been to a doctor for a physical evaluation in the past year, I work to connect them with a primary care physician to complete general bloodwork and a full physical evaluation. A biological assessment should include a physical health evaluation from a primary care physician to rule out any underlying medical causes for mental health symptoms. I also review prescription and over-the-counter medication and supplements, specifically ask how an individual is managing symptoms, and gather a general medical history overview.

Biological assessment should also include substance use history to determine if there are any functional impairments or addictions that may be affecting mental health treatment. During the beginning of the assessment process, I cover the basics of mandated reporting and reiterate that substance use is not reportable even if the substance is illegal. The legalization of marijuana in Virginia seems to have facilitated transparency for many individuals to share marijuana use, particularly concerning sleep and anxiety management. I work to provide a safe space for individuals to discuss their substance use patterns and will use motivational interviewing techniques during future sessions as appropriate.

Psychological Assessment

Psychological assessment begins during my intake paperwork, and individuals are presented with a thorough list of symptoms and requested to rate them on a scale of zero to five, with zero being not a problem and five meaning the problem or symptom is disabling. I have also used assessments such as the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) to determine the severity of functioning deficits, which can help identify treatment needs.

I often use specific assessment measures during the first one or two sessions to assist in a formal diagnosis and will continue to use assessments to track progress and monitor symptomology. Specific assessments have been beneficial in providing psychoeducation on mental health disorders and helping individuals recognize that their symptoms are not uncommon. From a CBT approach, evaluating how maladaptive thoughts and beliefs impact emotional and behavioral challenges is necessary to develop a formal treatment plan. Suicidal ideation can be a common symptom of multiple mental health disorders, and suicide assessment and safety planning interventions should be incorporated into treatment as appropriate. I have used the Columbia Suicide-Severity Rating Scale (CSSRS) to determine the severity risk of suicide to better inform decisions related to safety planning.

Social Assessment

When conducting a social assessment, I initially ask an individual to name individuals that are important to them and why. I will use open and closed-ended questions to discuss the dynamics within the relationship and how they have supported the individual in the past or present. Identifying barriers to interpersonal relationships is also essential, as actionable goals can be established to assist an individual in overcoming specific obstacles. Gaining a better

understanding of interpersonal dynamics may help determine how they have learned negative behavior patterns.

In recent years, the COVID-19 pandemic has influenced social gatherings and engagement in healthy activities such as group meetings, travel to visit friends and family, and generally limited time out of the home. The early stages of the COVID-19 pandemic were particularly stressful for college students and young adults transitioning into careers due to the limited connection with family and support systems and the isolation of work-from-home environments (López-Castro et al., 2021).

Multicultural Assessment

Multiple dimensions should be present in cultural assessments, including community, socio-economic status, gender identity, sexual orientation, ethnic background, and religious practices. I also make a point to reflect on experiences of acceptance and oppression to better understand each person's experience within their larger culture. Family history can provide additional information on various approaches to functioning and managing stress that can be influenced by cultural expectations and norms passed down through generations. Better cultural awareness and understanding help tailor my techniques and interventions by recognizing the impact of authority, how to communicate, and giving and receiving respect (Seligman & Reichenberg, 2014).

Spiritual Assessment

During my intake paperwork, individuals are asked for information on their spiritual life and whether it affects their mental health. During the first session, I provide an opportunity for the individual to clarify if they want to incorporate their religious/spiritual practices into sessions. Sometimes, I have worked with individuals who have experienced spiritual trauma, so I

am cautious about sharing my faith to provide a safe space to process their experiences. If someone discusses their faith as an essential part of their mental health, I will make a note to incorporate spiritual practices as a part of treatment.

Case Conceptualization Process

Although I practice using CBT techniques, my case conceptualization aligns more closely with a biopsychosocial method, although I also incorporate CBT explanatory methods. This allows me to remain closely aligned with an individual's identified needs and explanations for behaviors without prematurely attempting to form conclusions about their functioning. Case conceptualization includes four components: diagnostic formulation, clinical formulation, cultural formulation, and treatment formulation.

Diagnostic Formulation. Diagnostic formulation includes an individual's presentation and triggers and is used to inform the treatment process and outcome. The activating event, or precipitant, activates the problematic behavior or thinking that typically creates the presenting problem. The presenting problem often becomes more complex as treatment progresses, and a well-trained clinician will look for patterns in mental status, personal resources, and general functioning throughout treatment. Recognizing these patterns in functioning is critical to informing treatment approaches, as it can help predict and target specific maladaptive behaviors (Sperry & Sperry, 2020).

Clinical Formulation. Clinical formulation includes an individual's predisposition, or vulnerabilities, which influence their perception of an event, fostering patterns of adaptive or maladaptive functioning. Perpetuants are the individual's pattern of behaviors that exacerbate symptoms and describe why a person needs services or support; these are also impacted by predisposition and should be evaluated while referencing social, developmental, and health

history. Protective factors should also be considered, as these support recovery from mental health instability. The clinical formulation is a hypothesis explaining why someone is acting, thinking, feeling, and perceiving circumstances in a certain way (Sperry & Sperry, 2020).

Cultural Formulation. Cultural formulation includes cultural identity, acculturation and stress, beliefs and values, and the interaction between culture and personality. Challenges with acculturation often include racism-driven interactions and discrimination, which affect an individual's overall experience within a larger cultural system. Cultural explanations are important to understanding an individual's goals and experiences, as culture often influences perceptions surrounding reasons and consequences for behaviors or experiences (Sperry & Sperry, 2020). I work to approach cultural conversations with curiosity and allow the individual to explore various ways culture influences their situation. Personality constructs can also inform treatment, as personality may exacerbate challenges within the acculturation process.

Treatment Formulation. Treatment formulation focuses on how change can occur, including treatment goals, varying interventions, challenges to accomplishing goals, and how to overcome challenges as they occur. Treatment strategy and interventions fuel the direction of treatment and are informed by general goals and personality characteristics. Obstacles to treatment are identified, and the clinician and individual work together to identify ways to target and overcome challenges. The treatment prognosis includes the duration of services and the potential for positive outcomes, and an individual's readiness for change should be evaluated early in treatment. The CBT and biopsychosocial treatment formulation approach would identify specific needs for cognitive restructuring, exposure therapy, psychoeducation, social skills training, and identifying community supports (Sperry & Sperry, 2020).

DSM-5-TR Diagnostic Process

The diagnostic process begins with the initial service intake, but I often take two or three additional sessions to determine a specific diagnosis. One hour for an intake to services often does not provide me with enough information to establish a diagnosis unless an individual has received prior treatment resulting in a diagnosis. Even with a historical diagnosis, I proceed with standard symptomology questioning to complete my clinical determination for a diagnosis. Quantitative measures such as the level 1 cross-cutting symptom measure for DSM-5-TR diagnoses can provide a general overview of the intensity of symptomology to help determine the most accurate clinical diagnosis. These measures should be taken within the context of culture and individual practices to explore further how the person experiences their symptoms. The diagnosis informs treatment protocols and interventions, but considerations must include cultural influences, support systems, and physical wellness (Antony & Barlow, 2020; Owens & Woolgar, 2018).

Treatment Planning Process

Individuals receiving services should be active participants in identifying goals and subsequent treatment planning (Sperry & Sperry, 2020). Treatment planning helps maintain the focus of therapy to ensure an individual's needs are met through targeted interventions. I discuss the use of homework and its potential benefits in therapy, such as practicing skills outside the session or engaging in at least one self-care activity between sessions. The therapeutic alliance is vital for therapeutic effectiveness and to increase vulnerability during sessions. To build rapport, I often begin early sessions with reflective questions on the previous week and make a point to remember significant relationships or upcoming awards or challenges.

I have often found that individuals entering therapy are not familiar with or accepting of the complexity of emotional experiences and often restrict or avoid certain emotions altogether. Incorporating regular reflection on emotions during sessions and encouraging individuals to be more mindful of their emotional reactions typically increases the acceptance of emotional responses outside sessions. Teaching mindfulness techniques such as regulated breathing and grounding can help individuals learn how to manage their emotions both in and out of session (Buckley et al., 2018).

Internal dialogue often exacerbates negative emotions, as individuals may be critical of their physical and emotional reactions to an event. Thoughts generally impact emotions and behaviors and create a negative feedback loop that reinforces negative thoughts (Ehlers et al., 2021; Seligman & Reichenberg, 2014). As with emotions, being mindful of internal messages allows individuals to reflect on their inner dialogue and its possible source. I have worked with individuals on recognizing automatic thoughts and challenging them in a way that reduces their impact on emotions and behavior.

Identifying and targeting maladaptive behaviors is another vital therapy component to reduce stress levels and improve general functioning. Primary goals for services should include substance abuse, self-harm, and other risky behaviors during services. Often, individuals identify a specific behavior that they would like to change as a part of therapy or make statements suggesting a lack of understanding of their behavior. Techniques such as behavioral activation combined with healthy coping mechanisms can empower an individual to engage in ongoing changes in behavior (Dailey et al., 2014; Antony & Barlow, 2020).

Methods of Outcomes Assessment During the Treatment Phase

Reviewing goals during the treatment phase can provide structured feedback on the effectiveness of therapy and the need for intervention adjustments. Homework can also be an effective intervention to determine how an individual applies techniques outside of sessions and general progress in treatment. I also use the CBT triangle to provide psychoeducation on the connection between thoughts, behaviors, and emotions to promote healing as individuals become more aware of their internal processing (Seligman & Reichenberg, 2014).

I often incorporate the Dialectical Behavior Therapy (DBT) emotion wheel during sessions and prompt individuals to use the phrase "I feel _____ because _____" to reflect on their emotions in session. I also provide psychoeducation on the complexity of anger and assist the person in identifying the underlying emotion for their anger. Individuals with a trauma history often experience dissociation or emotional numbing, which presents challenges in connecting the emotion with the physical experience or memory (Antony & Barlow, 2020). For homework, I encourage using the wheel and phrase during the week to continue working on emotional identification and acceptance. As individuals become more in tune with their emotional experience, they often begin expressing more complex emotions during sessions without prompting. Processing challenging events can be emotionally triggering, so I have used scaling questions for emotions before, during, and after the narration of an event as I notice reactions while the person is sharing (Antony & Barlow, 2020).

Identifying and challenging negative core beliefs is essential for individuals to reframe their view of self and the world. I use a core belief checklist to assist individuals in identifying core beliefs and reviewing the way that this belief impacts various areas of functioning. I then work with the individual to identify examples of ways this belief is accepted, rejected, or

modified by experiences in their life. A natural progression of healing should include increased awareness of internal thoughts and their influence on emotions and behaviors. I use Socratic questioning techniques to challenge individuals to assess cognitive processing through a lens of fact or feelings and become aware of cognitive distortions (Seligman & Reichenberg, 2014).

As individuals participate in therapy, reflections on progress should occur at least every other session, but always as progress is identified. Copies of homework or in-session activities can be used to review progress, and individuals can be assigned similar worksheets to compare their past and present responses (Seligman & Reichenberg, 2014). I have used subjective units of distress scales (SUDS) with avoidance hierarchy to target specific challenging behaviors and encourage a person to continue facing their fear as they notice the SUDS score decreasing.

Aftercare and Maintenance Planning Process

Termination starts at the beginning of treatment, and an individual should be oriented to a general timeline of services at the first session. As sessions progress, I often lengthen the time between sessions to reduce reliance on therapy and encourage connection with external support systems. I always allow the individual to reach out between scheduled sessions if they feel they need additional support to foster advocacy and help facilitate feelings of safety. During treatment, it is not uncommon for me to incorporate a review of social engagement and ways an individual can connect with current or previous support systems in between sessions to reduce dependence on myself and the therapeutic relationship.

If an individual receives additional services such as medication management, I review the importance of compliance with medical appointments to monitor physical and mental health symptoms. We discuss ways the individual can continue connecting with support systems and increasing vulnerability with healthy people. As termination approaches, we review the

accomplishment of goals and symptoms the person can recognize if they are beginning to need support through therapy.

Case Study

This case study outlines the therapeutic process for Sarah, a 26-year-old female; her name has been changed to protect her identity as a part of this case presentation. Additional background information, including case conceptualization, can be found in Appendix A.

Initial Assessment and Orientation to Services

During the initial assessment, Sarah identified difficulty functioning due to symptoms of depression and anxiety, including hopelessness, isolation, crying spells, difficulty falling asleep, and poor appetite. At the time of assessment, Sarah met the criteria for *DSM-5-TR* F43.23 adjustment disorder with mixed anxiety and depression, acute due to her symptoms being directly related to her relationship ending and occurring for a period of less than six months. Sarah reported good physical health, although she was overdue for primary care and an OBGYN well visit. Sarah reported taking two or three 5mg of melatonin a night when she had difficulty sleeping. Building a therapeutic relationship is important for any individual, but it was crucial for Sarah as it was her first time in therapy, appointments were virtual, and she had just experienced a significant rupture in a trusted relationship. Sarah's orientation to counseling involved expectations for herself and the counselor and mandated reporting requirements. Sarah specifically wanted treatment to focus on improving her daily functioning and feeling back to the self from before the relationship.

Sarah identified the COVID-19 pandemic as a significant source of stress due to her immediate exposure to infection rates and data reports through work. She reported that the resulting lockdown had exacerbated the tension in her interpersonal relationship and increased

her isolation and depressive symptoms since she could not engage in activities she previously enjoyed. Sarah stated multiple times during the first few sessions that she felt she was losing the best part of her 20s due to her inability to attend concerts and bars and travel internationally with friends.

Treatment Planning and Goals

Sarah completed a sleep diary following the second session, highlighting the severity of her sleep challenges. According to the diary, Sarah would often not fall asleep until 3:00 am or 4:00 am due to anxiety and intrusive thoughts or avoidance of sleep due to fears of nightmares. She had to be awake for work by 8:00 am but often overslept and missed morning meetings. Sarah would then feel she needed a nap at the end of her workday and would sleep between 5:00 pm and 8:00 pm, which disrupted her evening's rest. Sleep stability became a primary goal due to Sarah's difficulty maintaining a consistent sleep schedule and engaging in restful behaviors before bed.

A primary goal of treatment also included Sara reducing feelings of guilt and responsibility for the abuse she experienced in her relationship. She made multiple statements during the initial stages of treatment that she felt responsible for her abuse due to not recognizing the unhealthy pattern of behavior and then remaining in the relationship despite an increase in abusive behavior. Normalizing feelings of guilt while also assisting Sarah in identifying the primary responsibility of her abuser was vital for her healing process (Young et al., 2021).

Sarah expressed difficulty recognizing her emotions and often stated she could not understand why she was crying or experiencing physical symptoms such as restlessness or increased heart rate. She could identify signs of anxiety when she was in specific locations she

visited with her ex-boyfriend or she knew he used to frequent. Still, she had difficulty recognizing these as trauma responses during the first few treatment sessions.

During her romantic relationship, Sarah became isolated from her previous support systems and often did not connect with her friend groups or family. As a result, Sarah felt alone in her distress and was unsure how to reconnect with previously supportive people. An additional treatment goal included working to establish other support systems and connecting with old friends to reduce feelings of loneliness.

Treatment Interventions and Outcomes

During the first session, Sarah was provided psychoeducation on the impact of sleep on mental health challenges. Within the first month of sessions, Sarah implemented a wind-down routine, including a warm shower, chamomile tea, mindfulness, and guided relaxation, which significantly improved her ability to fall asleep. Sarah was able to use her sleep patterns to recognize when her depressive symptoms were getting worse. Daily routines also were beneficial in reducing her likelihood of napping late in the day and consistently incorporating exercise into her daily schedule. She initially had difficulty completing a physical health evaluation but met with a primary care physician after the clinician expressed concerns about not receiving a physical health evaluation since college and intermittent challenges with staying asleep. During the visit, she was prescribed medication for anxiety, and recommendations were made regarding her use of over-the-counter sleep aid. As a result, Sarah was able to reduce her use of melatonin to one 5mg dose as needed and reported more consistently falling asleep by 12:00 am or 1:00 am.

Shortly after beginning treatment, Sarah experienced a significant increase in depression triggered by work stress and conflict with her roommate. It was determined that she was

experiencing a full depressive episode with different activating events and more intensive symptomology than she initially presented with at intake; her diagnosis was changed to F33.2 Major Depressive Disorder, recurrent, severe. This was determined using multiple symptomology assessments over the first four or five sessions as Sarah began reporting additional depressive cycles with periods of circumstantial relief. As her depression progressed, I inquired about suicidal thoughts and discussed medication management as an additional resource for depression. Sarah expressed my inquiry into safety concerns as a wake-up call on the severity of her symptoms. During periods of depression, she had difficulty maintaining certain self-care habits, and behavioral activation and motivational interviewing became important in increasing her awareness of why she was engaging in or avoiding a specific behavior. For instance, she evaluated her avoidance of physical activity despite recognized benefits and determined that she didn't always feel worth the energy to improve her mental health. As she began implementing behavioral changes by going for a walk on her work break and ending her day with a relaxing yoga exercise, Sarah noticed her overall mood and sleep improving. Sarah began recognizing the benefits of regular exercise on her general functioning and reported more consistent engagement in exercise activities.

As sessions continued, Sarah began reporting symptoms consistent with trauma responses and disclosed experiences of interpersonal violence and manipulation during her previous relationship. Using assessment measures for posttraumatic stress disorder (PTSD), it was determined that Sarah met the criteria for F43.1 PTSD, chronic. During periods of increased symptoms, Sarah would often retreat to her hometown for family support, to avoid reminders of her relationship in DC, and to receive accountability for routine and self-care activities. Her

depressive symptoms occurred outside of triggers for her PTSD, so the diagnosis of MDD was maintained.

Psychoeducation became a primary intervention to assist Sarah in better understanding the interactions between her physical wellness, mental health symptoms, and her traumatic experiences. I often reminded Sarah about the impacts of trauma on memory and verbal skills and how sights, sounds, smells, and even certain textures can remind a person of their trauma. I also included psychoeducation on the differences between cognitive and nervous system responses to events to help increase her awareness of when her limbic system was in control of her brain (McQuary & Schwartz, 2020; Young et al., 2021). We discussed the importance of the window of tolerance and how to recognize when she was moving out of this area and into hyper- or hypo-arousal. Sarah worked on practicing self-regulating skills in public, such as deep breathing and reminding herself of her safety. We also discussed options within her control if she was to encounter her ex-boyfriend while in public. Sessions included regular check-ins on emotional wellness using the DBT emotion wheel and discussed ways she recognized each emotion within herself throughout the week. Incorporating physical attunement to her body helped Sarah identify certain emotions more clearly and ways she may emotionally respond to certain physical sensations. For instance, Sarah could better recognize a racing heartbeat and nausea as physical connections to feelings of dread related to her ex-boyfriend. As her confidence grew, Sarah spent more time in the DC area instead of retreating for long periods of time to her hometown in New Jersey.

A consistent review of coping skill application was necessary for Sarah's treatment, as she was often easily overwhelmed and discouraged by recurrent anxiety symptoms. Sarah often said that she wished she would be better already or would have never entered the relationship.

Sarah would often re-trigger herself by looking through old photographs and texts of her ex-boyfriend and occasionally reached out to him at the beginning of treatment. She often expressed frustration that her mental health was still connected to her past relationship and had difficulty recognizing some of her achievements in the early stages of treatment. As Sarah progressed through treatment, she became more consistent at implementing thought-stopping and Socratic questioning to evaluate her thoughts before she acted on them, which limited her engagement in behaviors that exacerbated negative thoughts.

Sarah completed a life map of the previous two years of her relationship, which helped her identify multiple unhealthy behaviors and interactions in her relationship. As treatment progressed, she could verbally process events in the relationships and discuss the extent of her abuse. She identified core beliefs exacerbated during the relationship, including being worthless and never good enough, and worked to connect them to dialogues during her childhood. Sarah worked to reinvent herself and find her identity outside of the version of herself from college and recognized her internal dialogue as complicating her healing process. She became more consistent at recognizing cognitive distortions when they occurred, such as her tendency to over-generalize negative moments into negative aspects about herself or her future. She also acknowledged her tendency to see situations in black or white and how this was fostered in her childhood home environment. Sarah used positive journaling techniques multiple times per week to reflect on her daily experiences and challenge distorted perceptions of events.

Sarah experienced a significant stressor during therapy after finding out she was positive for the Herpes Simplex Virus (HSV) after engaging in unprotected sex with an unknown individual. This significantly impacted her view of herself and her worth as an individual, resulting in increased difficulty sleeping, negative intrusive thoughts, and general fear of the

future. She processed these with me verbally and recognized that she was engaging in self-sabotage behaviors, such as shutting out her support system and not adhering to a healthy daily schedule. Sarah acknowledged her embarrassment about her medical diagnosis and fears about her future partners' perceptions of her. She also completed a visit with her OB-GYN due to concerns with her health and was provided additional resources following her HSV diagnosis. Although this was not directly solved in therapy, Sarah connected with a support system, discussed her diagnosis with a trusted friend, and began working on targeted interventions for this stressor with limited support from therapy and limited the duration of the decline in her functioning.

During the working phase of therapy, Sarah had doubts that she would be accepted by old friends but was slowly able to reach out to past friends and reestablish connections. Behavioral activation was beneficial in helping Sarah recognize the potential benefits of spending time with friends and creating goals for herself to follow up with friends via text or phone call and to make specific plans with friends during weeknights and the weekend. Sarah utilized her support system more consistently during therapy and often connected with resources before she made impulsive decisions about her life or future. She completed additional trips with friends to new areas of the country to reduce isolation and participate in enjoyable activities. By the end of therapy, Sarah reconnected with a childhood friend and made plans to move with the friend to a new city closer to her hometown.

Sarah also began to recognize the difficulties she experienced in her career as a lack of interest in her work and the focus on services. She often reported that outcomes of the pandemic would create high workloads and extra meetings as her team often determined what recommendations on courses of action for the United States. As she recognized the importance

of spending time on her interests outside of work, she experienced less burnout and frustration during work hours. This new clarity helped her to identify other goals for herself, such as moving out of the area into a larger city. Sarah also communicated her desire to move to her boss and why it would not influence her commitment to her job.

Termination and Aftercare

As Sarah became more consistent in maintaining treatment progress and achieving goals, she expressed feeling more confident in continuing her success outside of therapy sessions. Sessions moved to biweekly, and then once-a-month check-ins on progress maintenance. Sarah consistently recognized when she was resorting to unhealthy coping habits and changed her behaviors more quickly than during the early stages of treatment. Sarah was able to manage symptoms when she was in DC but also recognized her desire to leave the city and have a fresh start in a new area.

I focused on treatment progress during the last two sessions and how Sarah maintained healthy choices. Time was spent reflecting on her growth over the past six months and how she had worked to improve her functioning significantly. I explored ways she would know if her symptoms were increasing and when she felt she might want to reconnect with services. Due to Sarah moving out of state, I provided her with information on how to find a new therapist in her area should she need services again. I also provided her with my contact information if she needed assistance establishing a new therapist.

Conclusion

My unique approach to treatment has allowed me to walk alongside numerous people as they enter and navigate their mental health healing journey. Using a TF-CBT-informed approach to assessment and techniques provides the clinical foundation for treatment protocols and

guidelines for approaching assessment and diagnosis. The medical model utilized by the mental health field increases challenges with assessment, although I have developed my system for evaluating symptomology from a biopsychosocial approach. This allows me to gather information unique to the individual presentation and navigate needs outside the CBT perspective. Using these techniques provided the resources and support to enable Sarah to move through a portion of her healing journey while we worked together. Sarah began to recognize her self-worth separate from her story as a survivor of interpersonal abuse. She strengthened the self-confidence she felt she had lost in the previous two years and ultimately moved forward from treatment with a better outlook on life and the opportunities before her.

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References

Antony, M. & Barlow, D. (2020). *Handbook of Assessment and Treatment Planning for Psychological Disorders* (3rd ed.). Guilford Press.

Buckley, T., Punkanen, M., & Ogden, P. (2018). The role of the body in fostering resilience: A sensorimotor psychotherapy perspective. *Body, movement, and dance in psychotherapy, 13*(4), 225-233. https://doi.org/10.1080/17432979.2018.1467344

Dailey, S., Gill, C. Karl, S., & Minton, C. (2014). *DSM-5 learning companion for counselors.* American Counseling Association.

Field, T., Miller, R., Beeson, E., & Jones, L. (2019). Treatment fidelity in neuroscience-informed cognitive-behavior therapy: A feasibility study. *Neurocounseling, 41*(4), 359-376. https://doi.org/10.17744/mehc.41.4.06

Ehlers, A., Wiedemann, M., Murray, H., Beierl, E., & Clark, D. (2021). Processes of change in trauma-focused CBT. *European Journal of Psychotraumatology, 12*. https://doi.org/10.1080/20008198.2020.1866421

López-Castro, T., Brandt, L., Anthonipillai, N., Espinsa, A., Melara, R. (2021). Experiences, impacts and mental health functioning during a COVID-19 outbreak and lockdown: Data from a diverse New York City sample of college students. *PLoS ONE, 16*(4), Article e0157223. https://doi.org/10.1371/journal.pone.0249768

McQuary, M. & Schwartz, A. (2020). *The Ultimate Trauma Treatment Certification Course* [MOOC lecture]. PESI, Inc. https://catalog.pesi.com/sales/bh_c_001529evg_ultimatetraumatreatmentcert_organic-260424

Owens, R., & Woolgar, S. (2018). Moving past pathology: Clinical applications of the balanced diagnostic impressions (DICE-PM) model. *Translational Issues in Psychological Science, 4*(3), 304-313. https://doi.org/10.1037/tps0000163

Seligman, L., & Reichenberg, L. (2014). *Theories of counseling and psychotherapy: Systems, strategies, and skills* (4th ed.). Pearson.

Sperry, L. & Sperry, J. (2020). *Case conceptualization: Mastering this competency with ease and confidence* (2nd ed.). Routledge.

Wymer, B., Ohrt, J., Morey, D., & Swisher, S. (2020). Integrating expressive arts techniques into trauma-focused treatment with children. *Journal of Mental Health Counseling, 42*(2), 124-139. https://doi.org/10.17744/mehc.42.2.03

Young, K., Chessell, Z., Chisholm, A., Brady, F., Akbar, S.. Vann. M., Rouf, K., & Dixon, L. (2021). A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events. *The Cognitive Behvaiour Therapist, 14*(26), 1-21. https://doi.org/10.1017/S1754470X21000192

Appendix A

Sarah is a 26-year-old single Caucasian female who presented to counseling after a difficult breakup with a significant other, isolation from social supports, and persistent symptoms of depression and anxiety. She lives in a Washington, DC suburb with two female roommates and worked from home at the National Institute of Health (NIH) due to the COVID-19 pandemic. She transitioned to her new job with NIH only a few months prior to the pandemic which increased feelings of instability in general functioning and created additional challenges in maintaining a healthy work-life balance. Due to isolation exacerbated by the pandemic and the unhealthy relationship, Sarah lost multiple support systems and felt as though none of her friends would reconnect with her due to her limited contact for a period of almost one year. This perception often prevented Sarah from reaching out to support systems for help, as she perceived rejection prior to any interaction with support.

Sarah reported natural predispositions to extraversion and a high desire to connect with others during her childhood and young adult life. This predisposition created cognitive dissonance as she had the desire to be outgoing again while also fearing judgment and criticism. Her fear of judgment from others was fostered by an emotionally manipulative and physically abusive relationship which often focused on her outward appearance and perceived awkwardness during social interactions. Sarah identified a primarily secure attachment with her mother, although it appeared to be disorganized at times due to moderate to high levels of avoidance and anxiety related to her mother's perception of her behaviors and experiences. This prevented Sarah from sharing her mental health challenges with her mom during the first month of sessions.

Sarah identified as a middle-class Caucasian American but did not specifically connect her identity to a larger community. Sarah expressed certain personality traits due to her childhood in New Jersey, including a more critical perception of herself and others as well as a generally outgoing and loud personality. Sarah also identified challenges at work due to her age, as she worked with individuals who were significantly older and had much more experience in the field. She discussed overall concerns about losing experiences in her 20s due to limitations during the COVID-19 pandemic.

Sarah presented to treatment with the goal to improve her overall functioning in all areas of living, as she was experiencing significant deficits with activities of daily living, social connection, and occupational performance. Primary goals included improving Sarah's quality of sleep and general management of depressive and trauma symptoms, as well as reducing isolation and increasing her natural support system. Secondary goals included improving her ability to challenge negative thought patterns which exacerbated depressive symptoms. Treatment will focus on triggering events that create difficult symptomology and a general decline in functioning. Specific treatment strategies include psychoeducation on sleep hygiene and various coping skills for depressive and trauma symptoms. Cognitive challenging and restructuring will be used to address negative views of herself and the world, and behavioral activation techniques will address isolation and anxiety about connecting with old and new friends. Sarah will be provided information on the benefits of medication management and physical health evaluations to monitor overall health.

An obstacle to treatment includes the use of teletherapy during the height of the COVID-19 pandemic. The lack of in-person sessions created challenges in monitoring body language and reduced opportunities for Sarah to leave her home. Sarah will likely avoid uncomfortable

feelings related to her trauma, and resort to numbing activities such as sleeping and scrolling social media. Developing rapport will be important to foster the clinician's ability to challenge Sarah to encourage behavioral change. Providing a safe and nonjudgmental environment will also be important to promote vulnerability with the therapist.

Termination of treatment may be challenging without addressing Sarah's difficulty in trusting herself to make healthy decisions without direct support from the therapist. Sarah will likely engage in codependent behaviors with others due to the emotional enmeshment she experienced with her mother as a teen and young adult. Soft transitions from treatment and a review of goals will be necessary to help Sarah identify ways she is actively pursuing goals with limited therapy support.

Appendix B

Problem or Concern	Measurable Treatment Goal	Treatment Interventions (Be Specific)	Expected Number of Sessions Devoted to Reaching This Goal	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/ Follow-Up (Means of maintaining treatment gains) (Include titration of treatment dosage)
Poor Sleep Habits	Sarah will implement at least 2 sleep hygiene techniques at least 4 nights per week.	Sarah will complete a sleep chart to increase awareness of sleep deficits. Sarah will review nightly routine during session and explore challenges to consistently adhering to routine.	3	Sarah will report a consistent bedtime before 12am. Sarah will report falling asleep within 30 minutes of laying down in her bed.	Sarah will follow the recommendation of her PCP to reduce the use of OTC melatonin. Sarah will monitor sleep patterns to improve awareness of depressive episodes.
Negative Worldview	Sarah will recognize when she is experiencing a cognitive distortion and identify the distortion using the CBT handout.	Sarah will evaluate distortions using provided CBT handouts at least once per day. Sarah will complete core belief checklist to discuss during session. Sarah will be educated on use of Socratic questioning.	8	Sarah will engage in thought-stopping and provide at least 5 minutes before using Socratic questioning techniques to make an inference on a situation. Sarah will identify a cognitive distortion within 15 minutes.	Sarah will continue positive journaling techniques to continue awareness of positive experiences and potential cognitive distortions.

Recurrent Trauma Triggers	Sarah will be able to verbalize at least 3 triggers for an increase in her trauma symptoms. Sarah will implement grounding and other healthy coping techniques in at least half of all episodes within at least 10 minutes. Sarah will report a reduction in intensity of symptoms to at least 30 using the SUDS scale.	Sarah will receive psychoeducation on trauma's impact of the brain including polyvagal technique. Sarah will practice healthy coping strategies at least once per day when not feeling dysregulated. Sarah will complete a SUDS check-in at least two times per day to increase awareness of emotional responses. Sarah will complete a life map of previous 2 years to identify traumatic experiences.	7	Sarah will be able to independently utilize daily SUDS rating scales to monitor the intensity of her distress. Sarah will self-report a reduction in the intensity of trauma symptoms and triggers using the SUDS scale. Sarah will discuss her experience with at least one trusted individual.	Sarah will reach out to counseling services in her new area or will reach out to clinician if she needs additional support to find a new therapist. Sarah will connect with a new therapist if her symptoms increase to 5 or higher out of 10.
Isolation and Feeling Alone	Sarah will increase contact with friends to at least two times per week.	Sarah will receive psychoeducation on the benefits of positive	6	Sarah will schedule weekly time with friends without	Sarah will prioritize at least one friendship over the coming months to

	Sarah will schedule at least one outing per month with a friend or group.	support systems at least once during the first month of services. Sarah will identify two new ways to meet friends and engage in at least one new activity to make a friend.		prompting during session. Sarah will report an increase in healthy friendships and identify 3 or more ways the relationship is healthy.	reduce feeling overwhelmed by new relationships. Sarah will utilize social media applications to foster new friendships in her new area.